Urology

Name: _____ Date: _____

Medical History

Circle Y or N for every Question

High Blood Pressure	Y	N	
Diabetes	Y	N	
Stroke	Y	N	
Kidney Stones	Y	N	
Kidney Failure/Dialysis	Y	N	
Heart Disease	Y	N	
Incontinence	Y	N	
Urinary Tract Infections	Y	N	
Artif. Joint or Heart Valves	Y	N	
Cancer (list type and date)	Y	N	

Smoking Y N

How much (packs/day) _____

Drinking (alcohol) Y N

How much

Other _____

_____

_____

_____

_____

_____

Surgical History

List any surgical procedures with approximate date

_____

_____

_____

_____

_____

_____

_____

Systems Review

Circle Y or N for every Question

Fever	Y	N	Tremors	Y	N	Excessive Thirst	Y	N
Chills	Y	N	Seizures	Y	N	Abdominal Pain	Y	N
Headache	Y	N	Chest Pain	Y	N	Nausea / Vomiting	Y	N
Weight Loss	Y	N	Wheezing	Y	N	Indigestion / Heartburn	Y	N
Hay Fever	Y	N	Frequent Cough	Y	N	Blood in Stool	Y	N
Sinus Problems	Y	N	Shortness of Breath	Y	N	Skin Rash	Y	N
Bleeding Problems	Y	N	Blood in Sputum	Y	N	Glaucoma	Y	N

Family History

Circle Y or N for any blood relatives affected

Diabetes	Y	N	Prostate Cancer	Y	N
Bleeding Problems	Y	N	Kidney Cancer	Y	N
Heart Disease	Y	N	Bladder Cancer	Y	N
Kidney Stones	Y	N	Other Cancer (list)		

Patient Registration Form

Welcome to our practice. Please complete the following information to the best of your ability.

Patient Information:

Last Name	First Name		Middle Initial
Social Security #	Date of Birth		Male or Female
Street Address		City/State	Zip Code
Cell Phone	Email	Home Phone #	Marital Status
Emergency Contact Name	Phone #	Relationship	

Employer Information:

Name	Work Number	Occupation
Address	City/State	Zip Code

Insurance Information:

Name of First Insurance Company		
Street Address	City/ State	Zip Code
Insurance ID Number	Local/Group Number	
Name of Secondary Insurance		
Street Address	City/State	Zip Code
Insurance ID Number	Local/Group Number	

Who is your Primary Care Physician or referring Dr.? _____

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefit. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: _____ Date: _____

Patient Medication Information

Today's Date: _____

Patient Name: _____

Date of Birth: _____ _____

Pharmacy Name: _____ City: _____

** Please fill out this form completely **with all doctor prescribed** medications**

Current Medication Name:	Mg (Dose):	How often do you take it:
Example: Levaquin	500 mg	1 per day

Allergies: _____

_____

_____

_____

_____

_____

For Office Use Only:

Imputed into computer: _____

Initials: _____

Account #: _____

Submit Reset